THE IMPACT OF MEDICAID/MEDICARE REGULATIONS ON RURAL LONG-TERM CARE FACILITIES IN WESTERN MONTANA

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NORTHWESTERN MONTANA AREAWIDE
HEALTH PLANNING COUNCIL

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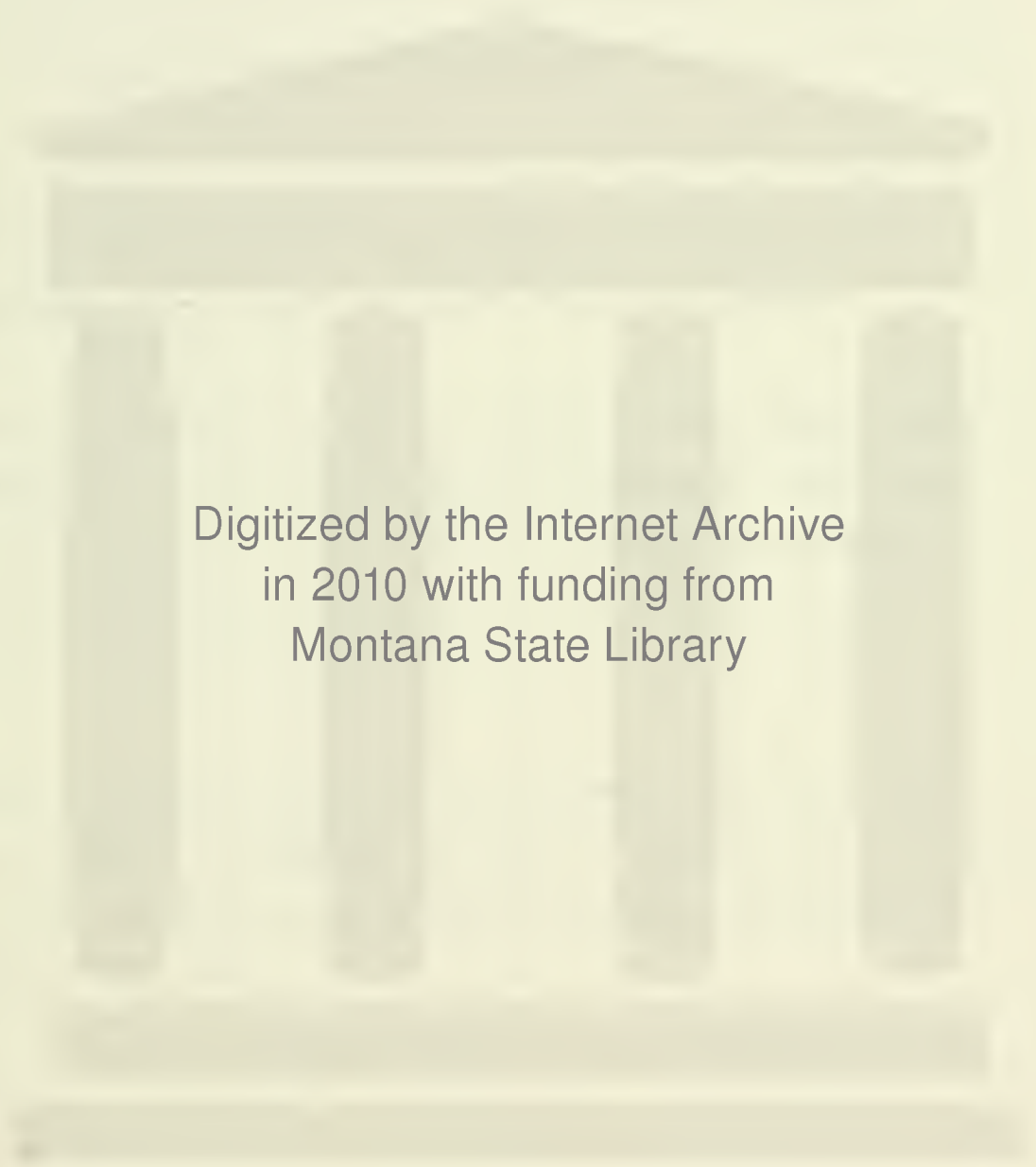

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TABLE OF CONTENTS

I. INTRODUCTION

This study evolved from a concern expressed by health care providers and planners over increasing government intervention into the health system without consideration to geographic differences. The study identifies some of the impacts of enforcement of the regulations, especially with respect to long-term care facilities in rural areas.

Most providers of long-term care do not question the government's role in protecting the public against harm or abuse from the health system. However, government regulation of the long-term care industry does not take into consideration geographic distinctions between rural and urban settings when government standards are developed. Where an urban area has a plentiful supply of medical manpower and expertise, these elements are not usually present in rural areas. The problems to be investigated in this report are those encountered by rural providers resulting from this lack of consideration for geographic differences.

A. METHODOLOGY

Region V, a state designated administrative district, was chosen as the study area for the following reasons: Region V is a medical trade area, according to recent patient origin data, and corresponds with the counties included under the Northwestern Montana Areawide Health Planning Council. The seven counties in Region V are Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli and Sanders. The major medical trade center is Missoula, Montana.

The facilities surveyed were long-term care facilities. As defined by R.C.M. 1971, Chapter 52, Volume 1, Part 4 of Title 69 Section 5201, a long-term care facility may be a profit or non-profit organization that provides any of the following services to a total of four or more people: (1) nursing care, (2) personal care, and (3) maintenance. The following types of facilities were surveyed:

Skilled Nursing Facilities - facilities furnishing continuous skilled nursing care and related services 24 hours a day, and

Intermediate Care Facilities - facilities furnishing limited nursing services and providing personal care and services to residents not requiring continuous skilled nursing care.

A survey instrument was developed to measure the impact

of the government standards covering the facilities under study. The survey population constituted 100 percent of the long-term care facilities in Region V. The survey instrument utilized is included as an Appendix. Data not footnoted in the text has been taken from the survey information.

II. AREA BACKGROUND

There are 21 long-term care facilities in Region V. The facilities range in size from eight to 107 beds. All the facilities studied are certified to participate in the Medicaid program and eight are also certified for Medicare. Lake and Mineral counties are the only counties having no facilities certified for Medicare. Geographically the long-term care facilities are distributed over Western Montana as follows:

County	No. of Facilities
Missoula	5
Flathead	4
Sanders	4
Lake	3
Ravalli	3
Lincoln	1
Mineral	1

The overall occupancy rate for 1974 in this region was 91.3 percent.[1] The occupancy for this region in the month of February 1975, was 94 percent. A 90 percent occupancy rate is considered desirable for optimal nursing home efficiency, according to the Montana State Plan for Hospitals and Medical Facilities Construction, Department of Health and Environmental Sciences.

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[1] Annual Report, 1974, Montana Department of Health and Environmental Sciences, Division of Hospital and Medical Facilities.

An important consideration in the long-term care field is the target population. In absolute numbers, the 65+ population of the area has been increasing over the past four decades. The percentage of the 65+ population has also shown a steady increase except for the period of 1960 to 1970. During this period there was a decrease in percentage in the three most populous counties and slight increases in four of the less populated counties. This greater number of older persons has increased the demand for long-term care services.

Another reason for the increased demand stems from the passage of Medicaid and Medicare legislation in 1965. Since that time the percentage of government spending for long-term care has increased dramatically. When the Medicaid/Medicare program was established in Montana in 1966, the Federal share of aggregate public program expenditures for nursing homes was 39 percent. By 1969, the Federal share of government nursing home care expenditures had increased to 59 percent, with 41 percent being provided by state and local government.[2] Region V gives an indication of the expanded role of government in the nursing home industry. This is demonstrated by reviewing the current breakdown of patients by method of payment. Fifty-eight

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[2]Personal Health Care Expenditures by State, Volume 1, Public Funds 1966 and 1969, United States Department of Health, Education and Welfare, Social Security Administration DHEW No. (SSA) 73-11906, United States Government Printing Office, Washington, D.C. 1973.

percent of the patients in long-term care facilities in Region V are paid for by the Medicaid programs, 37 percent are private pay patients, and the remaining 4 percent are paid by Medicare, Veteran's Administration, Supplemental Security Income or other sources.

It should be noted that less than .003 percent of the patients were receiving Medicare at the time of the study. As previously stated, only eight facilities in this Region are certified for Medicare. Providers indicated that the time involved in processing and record keeping for the Medicare program and the problems of determining a patient's eligibility for the program has made participation in the Medicare program so involved that it has deterred many of the facilities from becoming involved.

In summary, Region V's increasing number of people in the 65+ population, together with a large number of Medicaid/Medicare dependent patients, has caused a heavy reliance on government spending to maintain this region's nursing homes. This economic dependence makes it necessary for homes to meet and maintain standards for the participation in the Medicare/Medicaid programs.

III. SURVEY RESULTS

The regulations identified in this study are from the "Conditions of Participation" for skilled nursing and intermediate care facilities under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. These regulations were examined because of their impact on the long-term care industry. All of the facilities in the study are certified under one or both of these programs (Medicare or Medicaid).

A. INDUSTRY IMPACT OF REGULATIONS

To identify those standards creating difficulty for rural facilities, Social Security form 2567A, "Statement of Deficiencies and Plan of Compliance," was organized into three deficiency categories which include:

1. Paper Work Standards
   - a. Medical Records
   - b. Facility Plans
   - c. Committee and In-service Education
   - d. Other
2. Facility and Operational Standards
   - a. Life Safety Code
   - b. Operational Standards
3. Staffing Standards
   - a. Staffing Inadequacies
   - b. Consulting Agreements

Survey results in the three deficiency categories are listed in Table I, and show a trend of increasing violations from fiscal year 1974 to fiscal year 1975 with the exception of the Facility and Operational Standards category, which shows a decrease in the percent of violations. In fiscal year 1975 there was a 13 percent increase in Paper Work violations and almost a doubling of violations for Staffing deficiencies over the same period in 1974. However, there was a significant decrease (19 percent) in Facility and Operational Standards violations. It is evident that Paper Work and Staffing standards have created the most difficulties for long-term care facilities.

1. Paper Work Standards

Examination of the Paper Work Standards category reveals an increase in Medical Records violations (Section 1-a). Some examples of the violations cited are: improperly indexed files, lack of patient activity plans, and lack of physician or dentist signatures. In order to correct these violations, facility personnel must be aware that a problem exists. The facility can then take the necessary steps to provide expertise and trained staff who will develop and maintain an adequate records system. The problems that many rural providers face in this situation is locating the specialized manpower to assist them with organizing and maintaining the system.

TABLE I

VIOLATIONS BY DEFICIENCY

Deficiency Category	Percentage of Total Violations*	
	Fiscal 1974 Percent	Fiscal 1975 Percent
1. Paper Work Standards		
a. Medical Records	16	19
b. Facility Plans	4	8
c. Committee and In-service Education	7	8
d. Other	17	21
Sub-total	44	56
2. Facility and Operational Standards		
a. Life Safety Code	25	12
b. Operational Standards	22	16
Sub-total	47	28
3. Staffing Standards		
a. Staffing Inadequacies	4	7
b. Consulting Agreements	5	9
Sub-total	9	16
TOTAL	100	100

NOTE: Average number of violations per facility was 11 in 1974 and 15 in 1975.

*10 surveys from FY 74; 11 surveys from FY 75.

Source: "Statement of Deficiencies and Plan of Correction" SSA Form 2567(A), Social Security Administration.

Violations also increased in the Facility Plans category (Section 1-b). The increase was almost entirely attributable to the lack of either a facility maintenance plan or a disaster plan. During the interviewing, none of the administrators indicated difficulty in understanding standards covering maintenance plans. They did indicate problems with the disaster plan standard, which was added to the "Conditions of Participation" in January, 1974. This standard lacked interpretive guidelines for providers to follow.

Section 1-d in the Paper Work category showed the highest occurrence of violations. This was probably due to the catchall nature of the category and the diversity of violations involved. Typical violations in this category include lack of minutes from meetings, absence of job descriptions, and failure to develop written policies covering such areas as patient rights and disposition of personnel complaints. Most of the violations identified in this section are minor. Administrators indicated that corrective action was taken almost immediately upon discovery of a deficiency.

2. Facility and Operational Standards

In fiscal year 1975, violations in Facility and Operational Standards (category 2) decreased by 19 percent from 1974 survey information. Most of the violations

in this category are very specific and well-defined. They include such things as incorrect water temperature, absence of a smoke detection system or lack of sufficient therapy areas. A majority of the administrators interviewed seemed to have a good understanding of the regulations that are included in this category.

3. Staffing Standards

During fiscal year 1975 there was almost a doubling in the occurrence of violations in the Staffing Standards category. The increases appeared in both the Staffing Inadequacies and Consulting Agreements sections. The Staffing Inadequacies section (3-a) consists of violations in the area of in-house staffing. The Consulting Agreements section (3-b) includes violations of standards that require a consulting contract with specialized personnel such as registered dieticians, medical records technicians and social workers.

In the Staffing Inadequacies category (Section 3-a), a change in the regulations has contributed to the increased occurrence of violations. In January of 1974, all levels of intermediate care were combined under one set of standards. This change has caused the facilities that provide intermediate (B) level care to hire at least one nurse to provide a minimum of eight hours of nursing services per day.

This was not a provision in the previous set of standards and many facilities that were providing level (B) care were unaware of the change until the State survey.

The Consulting Agreements section (3-b) showed a similar increase in the occurrence of violations. Many administrators indicated that the consultant agreements standards are a recent requirement and compliance is dependent on whether this specialized personnel is available in their area. There is often a problem of manpower availability in the rural areas and the increase in violations in this section is an indication of this.

4. Violations Perceived as Unwarranted

To determine which violations administrators perceived as unwarranted, each respondent was asked to identify the deficiencies listed on his/her most recent "Statement of Deficiencies and Plan for Compliance" (SSA Form 2567A). In all, 29 violations were identified as unwarranted by nine of the 21 facilities responding to this question. Nine facility administrators felt that none of the violations cited were unwarranted. One nursing home respondent felt that all of the violations were unwarranted. One facility had not been inspected by the Survey Agency,

TABLE II

VIOLATIONS PERCEIVED AS UNWARRANTED

BY CATEGORY

Deficiency Category	Percentage of Total Violations By Categories (Perceived as Unwarranted)
1. Paper Work Standards	
a. Medical Records	24
b. Facility Plans	0
c. Committee and In-service Education	4
d. Other	28
Sub-total	56
2. Facility and Operational Standards	
a. Life Safety Code	3
b. Operational Standards	17
Sub-total	20
3. Staffing Standards	
a. Staffing Inadequacies	10
b. Consulting Agreements	14
Sub-total	24
TOTAL	100

Note: Average number of violations per facility perceived as unwarranted was 1.5.

and therefore could not respond, and one nursing home administrator did not want to consider the question.

When the 29 responses were categorized (Table II), 55 percent of the deficiencies identified as unwarranted were Paper Work related, 20 percent occurred in the Facility and Operational Standards category and the remaining 24 percent were in the Staffing Standards category. The average number of violations perceived as unwarranted was 1.56 per facility. The small homes (less than 30 beds) reported an average of 2.33 unwarranted violations per facility, while larger nursing homes (more than 30 beds) reported an average of 1.15 unwarranted violations per facility.

The largest percentage of Paper Work violations perceived as unwarranted occurred in Section 1-d (Other). Examples of the deficiences listed in this category are: the absence of patient care policies, hospital transfer agreements, and social agency service agreements. Many administrators felt that the majority of the agreements and policies were in existence at the time of evaluation, although not in the form of written documents. In addition, they felt that the violations cited were, in fact, a minor element in the regulation cited and identifying the entire regulation as being deficient was unjustifiable.

The second largest percentage of identified deficiences was in the Medical Records category (Section I-a). The majority of violations were due to the absence of dates or physician signatures on medical records. The administrators who identified these violations as unwarranted felt that the lack of information and interpretive guidelines were the primary reasons for non-compliance. In general, these violations were corrected as soon as they were cited.

Under the Paper Work category (Table II) all the violations considered to be unwarranted were felt to be minor, in view of the fact that the listed deficiences could be corrected immediately if interpretive guidelines were available and that they were only a single element in the larger regulation. Facility administrators reasoned that if the above two conditions were present in the survey situation, a violation should not be issued.

In the Facilities and Operational Standards (category 2) most of the violations involved Operational Standards. Examples of violations in this category are: failure to conduct disaster drills, improper emergency kits, and lack of therapy and dining areas for residents. There are two reasons

these violations were perceived as unwarranted. First, some administrators felt that because there were no interpretive guidelines available to correct these violations, they should not have been cited. Secondly, administrators in the smaller intermediate care facilities indicated that because of the financial constraints of their facilities, construction cost to meet standards would be prohibitive.

In the Staffing Standards category the majority of violations considered unwarranted were in the area of Consultant Agreements. The administrators identified social worker agreements and mental health specialists agreements as the areas that they felt violations were unwarranted. In regards to the social worker consultant contract, all the administrators responded that this agreement was in effect before the regulations were implemented. They stated that a county social worker is required to visit patients on Medicaid/Medicare regularly and provide information and referral services. Administrators resent having to establish a written contractual agreement for services that have been provided for years.

The Mental Health Specialist agreement was the other violation identified as unwarranted in the consulting agreements section. Administrators responded that

this regulation was too idealistic for rural areas. Administrators support the concept of providing the services but they are also aware that this type of specialized manpower is unavailable in most rural areas.

5. Summary of the Impacts

The results of categorization of State identified violations (Table I) and of the violations administrators perceived as unwarranted (Table II) indicate that paper work is a problem area for nursing homes. The regulations that are included in this category cover many aspects of health care, from facility policy to patient care plans. It is through a facility's written documentation that the State Survey Agency verifies that standards of care have been maintained.

There are some prerequisites to maintaining these standards of care and these are the areas in which providers are having problems. To begin with, it is necessary that each facility is aware of the regulations that are in effect. Administrators indicated that often this is not the case, but that it is not until the time of a State inspection that they become aware of a regulation. There was a willingness on the part of administrators to

comply with the standards but they often felt that the lack of available information about the standard had been a deterrent to compliance.

Another prerequisite to maintaining compliance in paper work is the availability of interpretive guidelines. An example of this problem is the requirement that each facility develop a disaster plan. This regulation was cited as a violation in many of the facilities in Region V. When questioned about this plan, the administrators responded that due to the absence of guidelines, they had encountered difficulty in plan development. There are many other examples of the problem of compliance resulting from the lack of guidelines or models.

To determine which organizations nursing home facilities rely upon for information on regulations, administrators were questioned about their sources. 71 percent indicated that the State Health Department supplied this information and approximately 40 percent also received information from the Montana Nursing Home Association. This makes the role of both the State Agency and the Nursing Home Association critical as a source of regulation information. Many of the problems that relate to a lack of information could be alleviated if both organizations would

take a more active role in communicating information on new regulations and would develop models and guidelines for the regulations that are presently in effect. The State should be responsible for developing and supplying administrators with models for such things as disaster plans, hospital transfer agreements and consulting agreements.

The other major problem area that is indicated by State identified violations (Table I) and violations perceived as unwarranted by administrators (Table II) is Staffing Standards. The regulations covered by this category include all the health manpower required for the operation of a long-term care facility.

Information presented above and discussion with administrators indicated that many of the problems in this area are due to the unavailability of health personnel and specialized manpower. In both cases administrators mentioned the difficulty a facility faces in locating and retaining qualified personnel in rural areas. Many of the specialized manpower, such as occupational therapists and mental health specialists, just do not exist in rural areas. The facilities are faced with attempting to recruit this manpower from more medically abundant areas and the problems of recruitment are extremely difficult. The

question of manpower is discussed in greater detail in the following section.

B. IMPACT OF MANPOWER STANDARDS

Two major problem areas for long-term care facilities are the paper work and health specialists areas. This problem can be demonstrated by examining the increase in violations in 1975 in these areas as shown in Table I. To alleviate these problems additional manpower is necessary. The types and cost of this manpower must be examined to determine the extent of the impact these problems have had on long-term care. Table III lists the additional specialized manpower employed since January 1974 and the respective annual cost for such employees. Total expenditures for 1975 will be approximately $82,000. To determine cost per patient day for the additional manpower, the total number of patient days[3] was divided by the additional yearly expenditures. This resulted in an additional 286 per patient day, or $102.20 per year for each patient in Region V.

The problems of paper work are necessarily solved through the increased use of manpower. Either present manpower must be utilized more effectively or additional manpower must be hired. When administrators were asked to respond to the question of recordkeeping, 62 percent indicated

[3]Annual Report - Hospitals and Related Facilities, 1974, Hospital and Medical Facilities Division, Montana Department of Health and Environmental Sciences.

TABLE III

COST TO COMPLY WITH SPECIALIZED MANPOWER STANDARDS

(Since January 1974)

MANPOWER	FULL-TIME ($)	PART-TIME ($)	CONSULTING ($)	YEARLY TOTAL ($)
Administrator			1,968.00	1,968.00
Medical Records Librarian	5,760.00	7,488.00	2,049.00	15,297.00
Clerical	10,224.00	7,540.00	2,049.00	17,764.00
Registered Nurse		6,306.56		6,306.56
Licensed Practical Nurse	10,444.80	2,828.80		13,273.60
Dietician		904.80	1,440.00	2,344.80
Cook		1,048.32		1,048.32
Physical Therapist		108.84		108.84
Occupational Therapist		1,258.82		1,258.82
Social Worker		1,258.82		1,258.82
Mental Health Specialist				
Recreation Director	4,944.00	11,323.00		16,267.00
Maintenance	3,840.00	2,080.00		5,920.00
TOTAL EXPENDITURE				81,556.94

NOTE: Cost figures are based on average rates paid by at least three facilities in Region V. Figures do not reflect travel expenses for consultants.

that it was necessary to hire additional personnel to maintain the Medicaid/Medicare standards. The area of recordkeeping requires the presence of two types of manpower, general clerical personnel and specialists in recordkeeping. The cost of added clerical personnel in Region V represents 22 percent of the total expenditures. Medical records librarians added in the region represent 19 percent of the total. Approximately $33,000 was expended on clerical and medical records manpower in Region V in the last year. Administrators identified Medicaid/Medicare requirements as the cause for this added manpower.

The increases in the area of specialized manpower directly responsible for patient care are in the fields of recreation directors and licensed practical nurses. The expenditures for this manpower are 21 percent and 16 percent respectively, of the total additional manpower expenditures.

The addition of recreation directors is directly attributable to the Medicaid/Medicare standards. Each facility is required by regulations to designate one staff person as responsible for the supervision of all patients' recreational activities. Many facilities have found it necessary to hire additional personnel to comply with this regulation.

The addition of licensed practical nurses is also directly attributable to the standards. In January of 1974, all levels of intermediate care (A and B) were incorporated under one set of standards. These standards require facilities licensed for intermediate (B) level care to provide a minimum of eight hours of nursing care per day. All the facilities licensed for intermediate (B) level care prior to the implementation of the new regulations have added LPN's to their staff.

Although the four types of manpower identified above, clerical, medical records librarian, recreation director and licensed practical nurses, represent 78 percent of the total manpower expenditures, Table III indicates that many other types of manpower are also necessary and that their cost is significant in the operation of a long-term care facility.

The problems of manpower availability and recruitment are faced by most rural providers. They find it particularly difficult to recruit and retain specialized manpower personnel, such as medical records technicians and qualified therapists. Although this specialized manpower may exist in more medically abundant areas within a few hours from a rural facility, a rural facility must make the financial reward and job description attractive enough to compensate for the distances involved.

The problems of recruitment and availability of specialists are common to rural areas. There are a number of alternatives available to rural areas that could alleviate some of the geographic constraints that are presently at work.

An alternative that would reduce the difficulties that individual providers face in this area would be to designate one agency or association to be responsible for the recruitment and financing of the specialized manpower for an entire region. Through this kind of program, each facility could contribute to the financing of the manpower, thus alleviating much of the time and expense spent by individual providers. If a sufficient number of facilities were involved, financial arrangements could be established that would attract the needed manpower. There might also be a possibility of arranging Federal assistance grants to supplement this type of program. The Montana Nursing Home Association would be the obvious organization to sponsor such a program.

Another alternative would be to involve the State Survey Agency in recruitment efforts. A system of information and referral could be established at the state level that would assist facilities with information on manpower available in the area and refer medical specialists to facilities that are in need.

C. IMPACT OF REIMBURSEMENT RATES AND SCHEDULES

The impact of reimbursement and its effects on cash flow was an area that administrators identified as a problem. Seventy-one percent of the respondents indicated that the time lapse between billing and final payment for Medicaid created problems in cash flow. (Because of the low utilization of Medicare in Western Montana [.003], rate and reimbursement information was not compiled for this agency.) But when administrators were asked to identify the amount of time that typically elapses, 71 percent reported that 30 days was the usual time lag. According to information from the Dikwood Corporation (the intermediary for Medicaid) in the month preceeding the survey, 40 percent of all nursing home claims were processed and paid by Medicaid within 30 days.[4] This would indicate that cash flow problems are not caused by the typical payment time lapse. In fact, Region V would seem to have an exceptionally good record as far as Medicare reimbursement schedules.

Reimbursement rates are another factor that could affect a facility's cash flow. These rates are determined on an individual basis, according to the levels of care and services available. The average reimbursement rates paid by Medicaid for the various levels of care are as follows:

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[4]James Yeater, Personnel Communication, Dikwood Corporation, Helena, Montana, April 1975.

Facility Type	Skilled	Intermediate A	Intermediate B
General (large and small)	$16.99	$14.40	$10.16
Large (more than 30 beds)	$16.43	$13.77	$10.63
Small (less than 30 beds)	$20.50	$18.25	$ 9.77

The rates do not show any appreciable differences except in the case of the small skilled and intermediate (A) care facilities. A comparison of these rates shows that the small skilled and intermediate (A) care facilities are receiving considerably higher payments than large homes providing the same level of care. These small skilled homes are physically co-located with hospitals. These higher costs are attributable to the increased costs of maintaining a facility that, because of the hospital, has a higher overhead in the areas of operating expenses and nursing services.

The problem of reimbursement and rates would seem to have a greater impact on consumers rather than providers. The physical co-location of small nursing homes with hospitals might not be in the best interest of either the consumer or the provider. To deal with this problem, the Northwestern Montana Areawide Health Planning Council should be encouraged to consider the economic appropriateness of locating a nursing home within a hospital, when a facility applies for such designation through the review process.

D. IMPACT OF DEVELOPMENTALLY DISABLED PATIENTS

Currently there is a trend in Montana to deinstitutionalize developmentally disabled persons and place them in Montana nursing homes. To reflect the impact of this new patient population on long-term care facilities, the number and placement of these persons within Western Montana facilities was examined.

The distribution of these patients in the region is as follows: 37 percent of the developmentally disabled patients are residing in two of the large (more than 30 beds) long-term care facilities, 30 percent of these patients are located in three small (less than 30 beds) intermediate care facilities where the homes' total population is developmentally disabled and the remaining 33 percent of the population is scattered throughout various long-term facilities in Region V.

As previously mentioned, the overall occupancy rate in 1974 was 91.3 percent for this region. In the month of February 1975, occupancy for this region was 94 percent. Included in this figure are 81 developmentally disabled patients, who previously were residents of the Boulder River School and Institution. These patients represent 8.3 percent of the total nursing home patient population, which is a significant contribution to the overall occupancy rate.

The intermediate care standards for facilities providing care to developmentally disabled patients has presented problems for some of these facilities. Three small facilities have plans to be redesignated as Group Homes as soon as licensing requirements are adopted by the State. They feel that new requirements will be more amenable for small rural facilities providing care to the developmentally disabled than the present intermediate care licensing requirements.

Providers are concerned because, currently, they are relying and expanding on the expectation of the continued presence of this population in their facilities. Any action by the State to remove these patients would result in injury to specific facilities and the region as a whole. In view of this, the providers that are caring for the developmentally disabled request that the State announce its long-range plans for the developmentally disabled patients now residing in nursing homes. Further, it is necessary that the State develop and implement Group Home regulations and make guidelines available to those homes that are now providing services for only developmentally disabled patients. Implementation of these recommendations would be beneficial for both nursing homes and patients that are currently in a state of flux because of the absence of guidelines and planning for developmentally disabled persons in Montana.

E. IMPACT OF SURVEY AGENCY

The Medical and Hospital Facilities Division of the State Department of Health and Environmental Sciences is the agency responsible for administering the Medicaid/Medicare surveys (SSA Form 2567A). This agency is the primary link between local nursing homes and the Federal government. Since the agency's role is to implement and enforce nursing home standards, their relationship to the facilities was examined.

Response of the administrators indicated that 71 percent viewed their relationship with the State Survey Agency as cooperative. Similarly high percentages of providers felt that the inspection process did identify nursing home deficiencies and that the enforcement of regulations was responsive to the needs of Western Montana. The question of adequacy of enforcement received mixed responses. Thirty-eight percent of the administrators felt that enforcement was adequate but 33 percent and 24 percent respectively, felt that enforcement was inconsistent or too stringent, only 5 percent felt that enforcement was inadequate.

The problems of how regulations are enforced has been a complaint of many administrators. In the past, facilities have relied on the issuance of waivers by the State Survey Agency. These waivers allow a facility to operate in violation of Federal standards, when there is intent on

the part of the facility to correct the violation within a specified time period. This has been a stop gap measure and does not deal with the problem of enforcement or implementation.

The State Survey Agency has also recognized both the problem of inconsistent enforcement and the burden many rural facilities have with meeting the standards. During a DHEW Region VIII State Survey Agency Conference[5], a paper on the problems of certification of facilities in health care programs was presented. The areas of inconsistent enforcement and the burden of rural versus urban nursing homes was discussed. The State Survey Agencies in Federal Region VIII felt that surveyors often lacked sufficient training before the implementation of regulations, which could account for so many administrators feeling the regulations were enforced inconsistently. The State Agencies also felt that the Federal government should consider geographic distinctions when adopting regulations because of the difficulty rural facilities face in dealing with the constraints of availability of financing, materials and craftsmen.

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[5]State Survey Agencies Conference, DHEW Region VIII, "Section I: Federal-State Relationships in Health Care Program Certification," Casper, Wyoming, 1974. (Mimeographed)

Both nursing home administrators and the State Agency recognized the problems of enforcement of regulations. Several alternatives are presented that address the problem of inconsistent and stringent enforcement of regulations. One alternative would be the adoption of Federal regulations that take into consideration geographic distinctions such as population base, manpower availability and the economic constraints of facilities in rural areas. Another alternative would be the relaxation of restrictions presently placed on rural facilities because of uniform enforcement of regulations. Also, providers could support decentralization of State Survey personnel into the region. This would make available technical assistance for those facilities that are in need and facilitate the dissemination and implementation of regulations. It would also provide a feedback mechanism for local providers and the State Survey Agency.

The adoption of any of these solutions would lead to a better relationship between State and local providers. It also answers some of the needs that providers feel are lacking in the area of regulation enforcement.

IV. COMMENTS AND RECOMMENDATIONS

Rural health providers have experienced many problems with the enactment of federal health care regulations, as has been demonstrated in this study. The basic cause of these regulations-enactment problems has been that the regulations themselves, with only few exceptions, were not written to apply to rural situations. The regulations do not consider such rural characteristics as scarcity of medical manpower, technical expertise, and materials.

To alleviate these regulation problems, the following recommendations were developed by the Plan Development Committee of Northwestern Montana Areawide Health Planning Council, based on the results of this study. These recommendations have been approved by the Board of Directors of the Council. The Plan Development committee is composed of health providers from each county in the Region and includes physicians, dentists, nursing home administrators, and hospital administrators. The following recommendations apply to long-term care regulations because these were the focus of this study, but this should not be taken to imply that similar problems do not exist in the enactment of regulations concerning other parts of the health care system.

A. Regulation Enactment Recommendations

1. The federal government should develop or revise long-term care regulations and standards to take into consideration geographic distinctions, including population base, manpower availability, and economic constraints. When regulations are enforced uniformly for both urban and rural health care systems, rural health providers experience undue hardships.

2. Sufficient time should be allowed between the adoption of new long-term care regulations and the implementation of these regulations, to allow survey personnel to be adequately trained and informed of the intent of the regulations.

3. The State Survey Agency should provide guidelines and interpretations of long-term care regulations to providers prior to their implementation. For example, the State should provide models for such required documents as disaster plans, hospital transfer agreements, and consulting contract agreements.

4. The State Survey Agency should locate at least one staff person in suitable locations throughout the state on a year-round basis, rather than sending in survey teams only once a year. This staff person would be responsible for assisting facilities in maintaining standards, informing them of new regulations, and providing a feedback mechanism between local providers and the State.

In addition to recommendations specifically proposing solutions to enactment problems, the Plan Development Committee proposed recommendations which should help alleviate certain problems of the long-term care health system specific to rural areas and/or to Montana.

B. Health System Recommendations

1. The Montana Nursing Home Association, possibly in conjunction with the State Survey Agency, should develop a regional manpower recruitment or re-distribution program to provide the specialized manpower required by current long-term care regulations.

2. To aid long-term care institutions develop long-range plans for patient care and facility utilization, the State should make clear its plan for de-institutionalization of developmentally-disabled persons. In addition the State should complete the development and implementation of Group Home licensing requirements, which apply to those facilities which care solely for developmentally-disabled patients.

3. The Northwestern Montana Areawide Health Planning Council should include in its long-term care recommendations in the 1975 Health Plan the recommendation that nursing homes not be physically located within hospitals as this is economically detrimental to the nursing home. Also, the Council should include all of the recommendations listed above within the long-term care recommendations of the Health Plan.

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APPENDIX

"NURSING HOME SURVEY"

NURSING HOME SURVEY

FOR THE

STUDY OF THE IMPACT OF STATE
AND FEDERAL REGULATIONS OF
HEALTH CARE FACILITIES

Under the Auspices of the
NORTHWESTERN MONTANA AREAWIDE HEALTH PLANNING COUNCIL
EDWARD MAHN, EXECUTIVE DIRECTOR

In Conjunction with

JOHN SHORT & ASSOCIATES, INC.

The following survey is to be jointly filled out on every nursing home in the Northwestern Montana area by staff and consultants. The information would be used to form the statistical base for the study on the impact of State and Federal Regulations on Health Care Facilities. Everyone's cooperation and support in this effort is required for the successful generation of the study.

Date of Interview _____

Interviewer _____

1. Administrative Information

Name and city facility _____

Name of administrator _____

Name of owner(s) _____

Length of ownership: less than 1 yr. _____ 1-2 years ____

2-4 years _____ 4 or more years _____

Length of operation as Licensed Nursing Home:

less than 1 year _____ 2-4 years _____

4-10 years _____ 4-10 years _____

over 10 years _____

Method of payment (% or number of patients in each category)

Medicare _____ VA contract _____ SSI _____

Medicaid _____ Private _____ Other _____

2. Physical Setting

Date facility was built _____

Originally built as: nursing home ____ private residence____

Other (specify) _____

Renovations in last ten years: List

Type	Purpose	Cost

3. Program Information

HOSPITALS (list)	NURSING HOMES (list)	OTHER (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Shared Services:

Service _____ Shared with _____

Service _____ Shared with _____

Service _____ Shared with _____

Patient Services:

Occupational therapy services from: _____

Recreational therapy services from: _____

Physical therapy services from: _____

Pharmacy services from: _____

Mental Health Consultation from: _____

House physician (name): _____

Nutrition consultation: _____

Social work consultation _____

Present staffing: RN's ___ LPN's ___ Aides ___ Dietary ___
(number)

Other _____

4. Has your facility been surveyed in the last year by the State Health Care Facility Surveyor's Agency?

Yes No (go to 5)

4a May I see a copy of the Survey Report (SSA 2567)?

Please explain any deficiencies on the Survey Report on which you have taken corrective action.

#	Correction

4b. Please explain any deficiencies listed on the Survey Report that you consider to be unwarranted.

#	Reason

5. In your opinion, does the State inspection process identify nursing home deficiencies?

☐ Yes ☐ No (If no, why?) _____

_____

_____

6. In your opinion, is the enforcement of regulations and guidelines responsive to the nursing home needs and conditions found in western Montana?

☐ Yes ☐ No (If no, why?) _____

_____

_____

7. In your opinion, is the role of the State Health Care Facility Surveyor's Agency.

a. ☐ cooperative,

b. ☐ neutral,

c. ☐ supportive, or

d. ☐ detrimental (Check one box only).

8. In your opinion, are State and Federal Nursing Home regulations and guidelines enforced.

a. ☐ inadequately,

b. ☐ inconsistently,

c. ☐ adequately, or

d. ☐ too stringently? (Check one box only).

9. Has the enforcement of State or Federal nursing home regulations caused financial difficulties at your facility?

☐ Yes No (go to 10).

9a. Please explain. _____

_____

_____

10. Has your nursing home had to hire extra personnel to comply with Medicaid or Medicare record keeping requirements?

☐ Yes ☐ No (go to 11).

10a. In order to comply with Medicare/Medicaid requirements, how many personnel have been hired in the following categories since January, 1974?

	Full Time	Part Time	Consulting Services
		(hrs./wk.)	(Visits/mo.)
Administrator			
Administrative Assistance			
Medical Records Librarian			
Clerical			
Registered Nurse			
Practical Nurse			
Dietician			
Cook			
Physical Therapist			
Occupational Therapist			
Social Worker			
Mental Health Specialist			
Recreation Director			
Maintenance			

11. Please describe the State or Federal regulations that have been most beneficial to the operation of your facility.

_____

_____

_____

12. Please describe the State or Federal regulations that have been most detrimental to the operation of your facility.

_____

_____

_____

13. In what ways do you gain information about existing or new nursing home regulations? _____

_____

_____

14. In your opinion, are these ways

a. ☐ adequate, (go to 15), or

b. ☐ inadequate?

14a. Would you suggest ways to overcome any inadequacies?

_____

_____

_____

15. We want to inquire as to the financial impacts of Medicaid and Medicare.
How many days typically elapse between billing and final payment from Medicaid? _____ days.
from Medicare? _____ days.

16. Does this time lapse introduce serious problems in your cash flow position?

☐ Yes ☐ No

17. What is your current Medicaid reimbursement rate for,

skilled care _____
intermediate A _____
intermediate B _____

17a. Is this rate currently adequate to provide proper care for your patients?

☐ Yes ☐ No (if no, why not?) _____

_____

_____

THANK YOU FOR YOUR COOPERATION.

NURSING HOME NAME ____

DATE ____

AGE	COUNTY OF ORIGIN (Home prior to admission)	SEX M= Male F= Female	BED TYPE S= Skilled A= Intermediate A B= Intermediate B	DATE OF ADMISSION